SECTION 12
ANESTHESIA

PROCEDURE CODES

Medicaid recognizes CPT anesthesia codes 00100 - 01999. The surgical procedure for which anesthesia services are being provided, must be a covered Medicaid service.

When the anesthesiologist or CRNA administers anesthesia for multiple surgical procedures for the same recipient on the same date of service during the same surgery, only the major procedure should be billed and the total number of minutes should be shown for all procedures.

Physicians and CRNAs may also bill for the insertion of intra-arterial lines, Swan Ganz catheters, central venous pressure lines, emergency intubation, and epidurals. These services are separately reportable when performed by the physician or CRNA using the following procedure codes. These codes should be billed **without** any modifier.

20550	36406	36660	62319	64415	64445	99100
31500	36410	36680	64400	64417	64450	99116
36000	36420	62273	64402	64418	64505	99135
36010	36425	62281	64405	64420	64508	99140
36011	36510	62282	64408	64421	64510	
36014	36600	62310	64410	64425	64520	
36400	36620	62311	64412	64430	64530	
36405	36625	62318	64413	64435	93503	

CPT Code 01996 (daily hospital management of epidural or subarachnoid continuous drug administration) is billed with a quantity of 1 and without any modifier.

SUPERVISION (MEDICAL DIRECTION)

Anesthesiologists must have a provider specialty of anesthesiology to bill for medical direction of qualified and licensed Anesthesiologist Assistants (AA) and CRNAs.

Anesthesiologists must supervise at least two, but not more than four anesthetists. When the anesthesiologist and anesthetist both are involved in a single anesthesia service (supervision of only one anesthetist), the service is considered to be personally performed by the anesthesiologist. No separate payment is allowed for the CRNA and a charge for supervision is inappropriate.

MODIFIERS

The following modifiers should be used for anesthesia services.

AA - Anesthesia services performed personally by anesthesiologist
QK - Medical direction of two, three or four concurrent procedures involving qualified individuals
QX - CRNA service, with medical direction by physician
QZ - CRNA service, without medical direction by physician

ANESTHESISA BILLING TIPS

- For paper claims with dates of service **prior** to October 16, 2003, bill the surgical procedure code with the appropriate modifier (AA, QK, QX or QZ) for the service. Do **not** use a type of service code.
- Administration of local infiltration, digital block, or topical anesthesia by the operating surgeon or obstetrician is included in the surgery fee, and a separate fee for administration should not be billed.
- Local anesthesia should not be reported separately. It is included in the procedure/surgery if provided in the physician's office; if provided in an Ambulatory Surgical Center (ASC) or outpatient department of the hospital, it is included in the facility charge; if provided on an inpatient basis, it is included in the accommodation revenue code for the facility.
- There may be an occasional need for anesthesia during CT scan or MRI services as a result of medically necessary circumstances, i.e., hyperactive child, mentally retarded individual, etc. To report this service, use procedure code 01922 (unlisted diagnostic radiologic procedure) with the appropriate modifier.
- Anesthesiologist monitoring telemetry in the operating room is non-covered.
- Routine resuscitation of newborn infants is included in the fee for the administration of the obstetrical anesthesia in low-risk patients.
- Anesthesiologist and CRNA services are not covered in the recovery room.
- Pain management is considered a part of postoperative care. However, if an epidural or intrathecal catheter is specifically inserted for pain management, it can be reimbursed. If already inserted for anesthesia, no separate payment is allowed.
- Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as extraordinary condition of patient, notable operative conditions, or unusual risk factors. These procedures may be reported in addition to anesthesia services. The following procedures should be billed:

  99100 - Anesthesia for patient of extreme age, under one year and over seventy.
  99116 - Anesthesia complicated by utilization of total body hypothermia.
  99135 - Anesthesia complicated by utilization of controlled hypotension.
  99140 - Anesthesia complicated by emergency conditions (specify).

  When billing the above procedure codes, the maximum quantity is always "1" as reimbursement is based on a fixed maximum allowable amount.